

**STANDARDIZED ICF-IID GATEKEEPING APPLICATION**

All sections of this application need to be completed in its entirety.

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| **Individual Information** |
| Individual Name: | Enter Name Here | Birth Date: | Enter MM/DD/YYYY |
| Street: | Enter Street Address | City: | Enter City  |
| County: | Enter Home County | Zip: | Enter Zip Code |
| Medicaid Number: | Enter Medicaid Number | MCO: | Choose an MCO. |
|  Who is requesting a referral for admission to an ICF-IID facility? Click or tap here to enter text. |
| Community Developmental Disabilities Organization (CDDO):Click or tap here to enter text.CDDO Contact Person: Click or tap here to enter text. |
| Has an IQ Evaluation been completed? Choose an item. | Date IQ Evaluation Completed:Click or tap to enter a date. |
| IQ Score: Number Is IQ 70 or below? Choose an item. | Diagnosis:Click or tap here to enter text. |
| [ ]  ***Check here if this is an Expedited Gatekeeping request due to health, safety, and welfare of the person.*** |
| [ ]  ***Check here if this is a transition from another ICF/IID facility.*** |

1. Is the individual a Kansas resident? Choose an item.
2. Has a Functional Assessment been completed within

the last 365 days? Choose an item.

1. Date Functional Assessment was completed Click or tap to enter a date.
2. Is individual currently receiving HCBS Waiver services? Choose an item.
3. Was a request for IDD Crisis submitted? Choose an item.
4. If yes to a), what was the crisis Decision? Choose an item.
5. If the person has a legal guardian, does the guardian approve of this request? Choose an item.
6. If there is a court-appointed legal guardian, does the court-appointed guardian

have authority to place individual in an ICF? (K.S.A. 59-3077) Choose an item.

***NOTE: If “NO” to any of the applicable questions (1-6) above, this request may not proceed.***

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| Does the individual have a legal guardian? Choose an item.**Parent (*if individual is under the age of 18*) or Guardian Information (*if individual has a court appointed guardian regardless of age*)** |
| Name: | Click or tap here to enter text. |
| Street: | Click or tap here to enter text. | City: | Click or tap here to enter text. |
| County: | Click or tap here to enter text. | Zip: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. | Fax Number: | Click or tap here to enter text. |
| E-Mail: | Click or tap here to enter text. |

Is this a request for placement in a public or private institution? [ ] Public [ ] Private

Where is the individual transitioning from? [ ] Community Setting [ ] Jail/Correctional Facility

[ ] Out-of-State [ ] Other: (explain) Click or tap here to enter text.

Why are community supports and services not able to meet the needs of the individual?

Click or tap here to enter text.

What are the individual’s barriers to successful community living?

Click or tap here to enter text.

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| **Community Services Explored** |
| Provide a list of the community services explored. The description should include the following:* Service Type (i.e., HCBS)
* Name of each provider/organization explored
* Method of exploration
* Reason service/provider is unable to provide services to the individual
* Duration of service utilization
* Reason service is not sufficient to meet the individual’s needs
* Was a request for Extraordinary Funding (EF) submitted? Choose an item. If Yes, What was EF decision? Choose an item. If No, Why not? Click or tap here to enter text.

 *Documents do not need to be attached to this request. Please retain the documentation in the home county CDDO’s files.* |
| **Services Explored and why insufficient:**Click or tap here to enter text. |

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| **Private ICF-IID** |
| * List all private ICF-IID facilities explored.
* Please retain written documentation by the ICF-IID explaining the reason the ICF-IID is not sufficient to meet the individual’s needs. *(Documents do not need to be included unless requested by KDADS ICF-IDD Program Manager.)*
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| **Institution Name and Why Insufficient:**Click or tap here to enter text.. |

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| **ICF-IID Gatekeeping Meeting** |
| Was the individual present at the gatekeeping meeting? Choose an item. |
| Was the guardian present at the gatekeeping meeting? Choose an item. |
| If no, indicate why the individual/guardian was not present.Click or tap here to enter text.  |
| CDDO Representative: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| MCO Care Coordinator: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| Targeted Case Manager: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Contact: | Click or tap here to enter text. |
| Other: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. |
| Other: | Present at Meeting: Choose an item. | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. |
| Date of Gatekeeping meeting: Click or tap to enter a date. |
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| **Gatekeeping Efforts** |
| Does the individual have a current Person-Centered Service Plan? Choose an item.Person-Center Service Plan includes:* Support Plan (required)
* Behavioral Support Plan (if applicable)
* Individual Education Plan (if applicable)

If yes, submit copy of Person-Centered Service Plan with gatekeeping application.If no service plan, attach support plan. |
| List individual’s strengths that could contribute to their success in the community.Click or tap here to enter text. |
| Does the individual have health or medical related needs that exceeds services available in the community? If yes, please list the needs and the reason the needs are not able to be met in the community.Click or tap here to enter text. |
| What are the individual’s active treatment needs? (refer to CFR §483.440(a))Click or tap here to enter text. |

**Individual/Guardian Consent**

As the individual or guardian, I attest that *(initial by each statement):*

 The information provided above for the gatekeeping application is accurate to the best of my knowledge.

 I have reviewed the gatekeeping application and agree with the contents provided in the document.

 I permit the submission of the gatekeeping application to the Kansas Department for Aging and Disability Services (KDADS) to review for final admission determination.

Individual/Guardian Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CDDO Comments** |
| Click or tap here to enter text. |
| CDDO Director Signature |  | Date |  |

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| **MCO Comments** |
| Click or tap here to enter text. |
| MCO LTSS Signature |  | Date: |  |

\*If the individual contacts the CDDO to provide additional information for the gatekeeping application. It is the responsibility of the CDDO representative to update the gatekeeping application with the additional information and obtain individual/guardian signature next to the update information. Failure to obtain the necessary signature will result in invalid information for the gatekeeping application and will be disregarded for KDADS ICF-IID admission review.

***This document will not be considered unless all signatures are present.***

***This document will not be considered unless both the CDDO and the MCO Comments are completed.***

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| KDADS Review |
| Date Received | Click or tap to enter a date. | Determination Date | Click or tap to enter a date. |
| Determination:  | [ ] Approved | [ ] Denied | [ ] Other |
| Comments:Click or tap here to enter text. |
| Reviewed by: |  |